Outline of coverage

Medicare Supplement Insurance

Benefit Plans A, B, F, G, High Deductible G, N

Arizona

Underwritten by

Aetna Health and Life Insurance Company

AetnaSeniorProducts.com

AHLMS04865AZ

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Rates effective: 03/2024 A

AETNA HEALTH AND LIFE INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
BENEFIT PLANS AVAILABLE: A, B, F, G, HIGH DEDUCTIBLE G, N
Benefit Chart of Medicare Supplement Plans Sold on or After January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and High Deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2024[2]					**$7,060[2]**	**$3,530[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,800** before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

Aetna Health and Life Insurance Company
Annual Premiums
For Use in ZIP Codes: 850-853 and 857
Female Rates

Rates effective 3/1/2024

ISSUE AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,718	1,961	2,156	1,741	574	1,259
66	1,730	1,976	2,172	1,752	579	1,273
67	1,757	2,006	2,205	1,780	588	1,299
68	1,792	2,047	2,250	1,817	600	1,334
69	1,833	2,096	2,304	1,858	614	1,370
70	1,877	2,144	2,358	1,902	628	1,405
71	1,922	2,193	2,413	1,948	643	1,439
72	1,964	2,244	2,468	1,991	657	1,473
73	2,008	2,296	2,522	2,035	673	1,504
74	2,056	2,348	2,582	2,084	688	1,539
75	2,102	2,400	2,639	2,131	703	1,574
76	2,149	2,455	2,699	2,178	719	1,609
77	2,202	2,514	2,764	2,230	737	1,647
78	2,250	2,570	2,827	2,281	753	1,685
79	2,300	2,627	2,889	2,332	770	1,723
80	2,353	2,688	2,956	2,385	788	1,764
81	2,408	2,751	3,025	2,439	806	1,804
82	2,458	2,810	3,089	2,494	823	1,844
83	2,517	2,874	3,160	2,548	843	1,886
84	2,570	2,936	3,230	2,605	860	1,926
85	2,644	3,020	3,322	2,680	885	1,981
86	2,701	3,084	3,391	2,737	904	2,023
87	2,757	3,150	3,463	2,795	923	2,064
88	2,813	3,213	3,536	2,853	942	2,110
89	2,872	3,282	3,608	2,912	961	2,153
90	2,931	3,347	3,682	2,968	981	2,195
91	2,988	3,415	3,755	3,030	1,001	2,240
92	3,047	3,481	3,829	3,089	1,020	2,284
93	3,105	3,547	3,899	3,147	1,040	2,326
94	3,160	3,611	3,972	3,205	1,058	2,369
95	3,216	3,673	4,038	3,259	1,077	2,411
96	3,266	3,732	4,102	3,310	1,093	2,447
97	3,309	3,780	4,157	3,355	1,107	2,481
98	3,343	3,819	4,201	3,391	1,119	2,506
99+	3,364	3,843	4,227	3,408	1,126	2,520

ISSUE AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,909	2,178	2,397	1,933	639	1,400
66	1,923	2,194	2,413	1,949	643	1,414
67	1,952	2,229	2,451	1,978	653	1,443
68	1,990	2,274	2,500	2,018	666	1,481
69	2,037	2,327	2,559	2,063	682	1,524
70	2,085	2,381	2,618	2,114	698	1,561
71	2,133	2,437	2,680	2,163	715	1,598
72	2,185	2,493	2,742	2,213	730	1,635
73	2,232	2,550	2,801	2,262	748	1,672
74	2,284	2,611	2,868	2,314	764	1,710
75	2,337	2,667	2,934	2,367	782	1,747
76	2,388	2,728	2,999	2,420	799	1,787
77	2,445	2,794	3,071	2,479	819	1,829
78	2,500	2,856	3,141	2,535	837	1,873
79	2,555	2,919	3,209	2,589	855	1,914
80	2,614	2,986	3,284	2,650	875	1,961
81	2,676	3,057	3,362	2,711	895	2,003
82	2,733	3,123	3,431	2,771	915	2,048
83	2,796	3,193	3,512	2,833	936	2,096
84	2,856	3,262	3,588	2,893	956	2,140
85	2,940	3,356	3,691	2,980	983	2,201
86	3,001	3,429	3,767	3,040	1,004	2,248
87	3,063	3,499	3,849	3,104	1,026	2,296
88	3,127	3,572	3,926	3,169	1,046	2,342
89	3,190	3,645	4,009	3,234	1,068	2,390
90	3,257	3,719	4,091	3,299	1,090	2,439
91	3,322	3,792	4,173	3,366	1,112	2,490
92	3,384	3,868	4,252	3,434	1,134	2,535
93	3,450	3,943	4,335	3,497	1,155	2,584
94	3,513	4,013	4,413	3,562	1,176	2,631
95	3,574	4,081	4,489	3,621	1,197	2,678
96	3,628	4,145	4,558	3,678	1,214	2,720
97	3,678	4,200	4,619	3,727	1,231	2,757
98	3,717	4,246	4,668	3,766	1,244	2,785
99+	3,737	4,270	4,697	3,787	1,251	2,800

The above rates do not include the $20 one-time policy fee.

To calculate a 7% household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health and Life Insurance Company

Annual Premiums

For Use in ZIP Codes: 850-853 and 857

Male Rates

Rates effective 3/1/2024

ISSUE AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,976	2,255	2,481	2,001	661	1,449
66	1,989	2,272	2,498	2,015	666	1,465
67	2,020	2,306	2,538	2,047	676	1,494
68	2,060	2,353	2,589	2,087	690	1,534
69	2,110	2,410	2,650	2,137	705	1,576
70	2,159	2,467	2,710	2,188	722	1,615
71	2,208	2,522	2,774	2,239	740	1,655
72	2,260	2,582	2,837	2,291	755	1,693
73	2,311	2,640	2,900	2,341	774	1,730
74	2,363	2,701	2,970	2,397	791	1,770
75	2,419	2,760	3,036	2,450	809	1,809
76	2,471	2,824	3,105	2,506	827	1,850
77	2,532	2,891	3,178	2,565	847	1,892
78	2,589	2,956	3,250	2,624	867	1,938
79	2,644	3,020	3,323	2,680	885	1,981
80	2,706	3,091	3,399	2,744	906	2,030
81	2,770	3,164	3,479	2,807	927	2,074
82	2,827	3,231	3,553	2,867	946	2,120
83	2,893	3,305	3,634	2,932	969	2,168
84	2,956	3,378	3,711	2,995	989	2,214
85	3,042	3,475	3,818	3,084	1,018	2,276
86	3,105	3,547	3,899	3,149	1,039	2,326
87	3,171	3,622	3,983	3,213	1,062	2,375
88	3,235	3,696	4,065	3,279	1,083	2,426
89	3,302	3,774	4,151	3,350	1,105	2,474
90	3,369	3,850	4,234	3,415	1,128	2,523
91	3,437	3,926	4,317	3,484	1,151	2,575
92	3,507	4,005	4,401	3,551	1,173	2,626
93	3,572	4,078	4,485	3,618	1,196	2,677
94	3,636	4,154	4,568	3,685	1,218	2,724
95	3,698	4,225	4,646	3,750	1,238	2,771
96	3,755	4,291	4,716	3,806	1,257	2,814
97	3,806	4,347	4,782	3,858	1,273	2,853
98	3,847	4,394	4,831	3,898	1,287	2,882
99+	3,868	4,420	4,861	3,921	1,295	2,898

ISSUE AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,193	2,505	2,756	2,224	735	1,609
66	2,209	2,523	2,774	2,240	740	1,625
67	2,244	2,564	2,820	2,274	751	1,661
68	2,289	2,616	2,877	2,321	766	1,704
69	2,342	2,677	2,943	2,374	785	1,752
70	2,399	2,740	3,013	2,432	802	1,796
71	2,454	2,801	3,084	2,485	822	1,839
72	2,512	2,869	3,154	2,544	840	1,880
73	2,567	2,932	3,221	2,601	860	1,923
74	2,627	3,001	3,299	2,662	879	1,967
75	2,688	3,066	3,374	2,722	899	2,010
76	2,746	3,138	3,449	2,784	919	2,056
77	2,812	3,211	3,531	2,850	942	2,104
78	2,875	3,285	3,613	2,915	962	2,155
79	2,940	3,356	3,691	2,979	983	2,202
80	3,008	3,435	3,776	3,048	1,006	2,254
81	3,077	3,513	3,866	3,118	1,029	2,305
82	3,141	3,590	3,946	3,185	1,052	2,354
83	3,216	3,671	4,038	3,258	1,077	2,411
84	3,285	3,752	4,127	3,329	1,100	2,460
85	3,381	3,859	4,246	3,427	1,130	2,531
86	3,451	3,943	4,335	3,498	1,154	2,585
87	3,524	4,025	4,425	3,572	1,179	2,640
88	3,595	4,107	4,516	3,645	1,203	2,694
89	3,669	4,192	4,610	3,720	1,228	2,749
90	3,744	4,276	4,702	3,793	1,254	2,807
91	3,819	4,362	4,797	3,871	1,279	2,862
92	3,892	4,448	4,890	3,947	1,304	2,916
93	3,968	4,532	4,982	4,021	1,329	2,972
94	4,041	4,616	5,074	4,094	1,353	3,026
95	4,110	4,695	5,161	4,163	1,377	3,079
96	4,171	4,767	5,242	4,228	1,396	3,128
97	4,228	4,831	5,313	4,287	1,415	3,170
98	4,273	4,882	5,369	4,332	1,430	3,204
99+	4,299	4,910	5,401	4,357	1,439	3,220

The above rates do not include the $20 one-time policy fee.

To calculate a 7% household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)

Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Aetna Health and Life Insurance Company

Annual Premiums

For Use in: Rest of State

Female Rates

Rates effective 3/1/2024

ISSUE AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,576	1,799	1,978	1,597	527	1,155
66	1,587	1,813	1,993	1,607	531	1,168
67	1,612	1,840	2,023	1,633	539	1,192
68	1,644	1,878	2,064	1,667	550	1,224
69	1,682	1,923	2,114	1,705	563	1,257
70	1,722	1,967	2,163	1,745	576	1,289
71	1,763	2,012	2,214	1,787	590	1,320
72	1,802	2,059	2,264	1,827	603	1,351
73	1,842	2,106	2,314	1,867	617	1,380
74	1,886	2,154	2,369	1,912	631	1,412
75	1,928	2,202	2,421	1,955	645	1,444
76	1,972	2,252	2,476	1,998	660	1,476
77	2,020	2,306	2,536	2,046	676	1,511
78	2,064	2,358	2,594	2,093	691	1,546
79	2,110	2,410	2,650	2,139	706	1,581
80	2,159	2,466	2,712	2,188	723	1,618
81	2,209	2,524	2,775	2,238	739	1,655
82	2,255	2,578	2,834	2,288	755	1,692
83	2,309	2,637	2,899	2,338	773	1,730
84	2,358	2,694	2,963	2,390	789	1,767
85	2,426	2,771	3,048	2,459	812	1,817
86	2,478	2,829	3,111	2,511	829	1,856
87	2,529	2,890	3,177	2,564	847	1,894
88	2,581	2,948	3,244	2,617	864	1,936
89	2,635	3,011	3,310	2,672	882	1,975
90	2,689	3,071	3,378	2,723	900	2,014
91	2,741	3,133	3,445	2,780	918	2,055
92	2,795	3,194	3,513	2,834	936	2,095
93	2,849	3,254	3,577	2,887	954	2,134
94	2,899	3,313	3,644	2,940	971	2,173
95	2,950	3,370	3,705	2,990	988	2,212
96	2,996	3,424	3,763	3,037	1,003	2,245
97	3,036	3,468	3,814	3,078	1,016	2,276
98	3,067	3,504	3,854	3,111	1,027	2,299
99+	3,086	3,526	3,878	3,127	1,033	2,312

ISSUE AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,751	1,998	2,199	1,773	586	1,284
66	1,764	2,013	2,214	1,788	590	1,297
67	1,791	2,045	2,249	1,815	599	1,324
68	1,826	2,086	2,294	1,851	611	1,359
69	1,869	2,135	2,348	1,893	626	1,398
70	1,913	2,184	2,402	1,939	640	1,432
71	1,957	2,236	2,459	1,984	656	1,466
72	2,005	2,287	2,516	2,030	670	1,500
73	2,048	2,339	2,570	2,075	686	1,534
74	2,095	2,395	2,631	2,123	701	1,569
75	2,144	2,447	2,692	2,172	717	1,603
76	2,191	2,503	2,751	2,220	733	1,639
77	2,243	2,563	2,817	2,274	751	1,678
78	2,294	2,620	2,882	2,326	768	1,718
79	2,344	2,678	2,944	2,375	784	1,756
80	2,398	2,739	3,013	2,431	803	1,799
81	2,455	2,805	3,084	2,487	821	1,838
82	2,507	2,865	3,148	2,542	839	1,879
83	2,565	2,929	3,222	2,599	859	1,923
84	2,620	2,993	3,292	2,654	877	1,963
85	2,697	3,079	3,386	2,734	902	2,019
86	2,753	3,146	3,456	2,789	921	2,062
87	2,810	3,210	3,531	2,848	941	2,106
88	2,869	3,277	3,602	2,907	960	2,149
89	2,927	3,344	3,678	2,967	980	2,193
90	2,988	3,412	3,753	3,027	1,000	2,238
91	3,048	3,479	3,828	3,088	1,020	2,284
92	3,105	3,549	3,901	3,150	1,040	2,326
93	3,165	3,617	3,977	3,208	1,060	2,371
94	3,223	3,682	4,049	3,268	1,079	2,414
95	3,279	3,744	4,118	3,322	1,098	2,457
96	3,328	3,803	4,182	3,374	1,114	2,495
97	3,374	3,853	4,238	3,419	1,129	2,529
98	3,410	3,895	4,283	3,455	1,141	2,555
99+	3,428	3,917	4,309	3,474	1,148	2,569

The above rates do not include the $20 one-time policy fee.

To calculate a 7% household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)

Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Aetna Health and Life Insurance Company

Annual Premiums

For Use in: Rest of State

Male Rates

Rates effective 3/1/2024

ISSUE AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,813	2,069	2,276	1,836	606	1,329
66	1,825	2,084	2,292	1,849	611	1,344
67	1,853	2,116	2,328	1,878	620	1,371
68	1,890	2,159	2,375	1,915	633	1,407
69	1,936	2,211	2,431	1,961	647	1,446
70	1,981	2,263	2,486	2,007	662	1,482
71	2,026	2,314	2,545	2,054	679	1,518
72	2,073	2,369	2,603	2,102	693	1,553
73	2,120	2,422	2,661	2,148	710	1,587
74	2,168	2,478	2,725	2,199	726	1,624
75	2,219	2,532	2,785	2,248	742	1,660
76	2,267	2,591	2,849	2,299	759	1,697
77	2,323	2,652	2,916	2,353	777	1,736
78	2,375	2,712	2,982	2,407	795	1,778
79	2,426	2,771	3,049	2,459	812	1,817
80	2,483	2,836	3,118	2,517	831	1,862
81	2,541	2,903	3,192	2,575	850	1,903
82	2,594	2,964	3,260	2,630	868	1,945
83	2,654	3,032	3,334	2,690	889	1,989
84	2,712	3,099	3,405	2,748	907	2,031
85	2,791	3,188	3,503	2,829	934	2,088
86	2,849	3,254	3,577	2,889	953	2,134
87	2,909	3,323	3,654	2,948	974	2,179
88	2,968	3,391	3,729	3,008	994	2,226
89	3,029	3,462	3,808	3,073	1,014	2,270
90	3,091	3,532	3,884	3,133	1,035	2,315
91	3,153	3,602	3,961	3,196	1,056	2,362
92	3,217	3,674	4,038	3,258	1,076	2,409
93	3,277	3,741	4,115	3,319	1,097	2,456
94	3,336	3,811	4,191	3,381	1,117	2,499
95	3,393	3,876	4,262	3,440	1,136	2,542
96	3,445	3,937	4,327	3,492	1,153	2,582
97	3,492	3,988	4,387	3,539	1,168	2,617
98	3,529	4,031	4,432	3,576	1,181	2,644
99+	3,549	4,055	4,460	3,597	1,188	2,659

ISSUE AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,012	2,298	2,528	2,040	674	1,476
66	2,027	2,315	2,545	2,055	679	1,491
67	2,059	2,352	2,587	2,086	689	1,524
68	2,100	2,400	2,639	2,129	703	1,563
69	2,149	2,456	2,700	2,178	720	1,607
70	2,201	2,514	2,764	2,231	736	1,648
71	2,251	2,570	2,829	2,280	754	1,687
72	2,305	2,632	2,894	2,334	771	1,725
73	2,355	2,690	2,955	2,386	789	1,764
74	2,410	2,753	3,027	2,442	806	1,805
75	2,466	2,813	3,095	2,497	825	1,844
76	2,519	2,879	3,164	2,554	843	1,886
77	2,580	2,946	3,239	2,615	864	1,930
78	2,638	3,014	3,315	2,674	883	1,977
79	2,697	3,079	3,386	2,733	902	2,020
80	2,760	3,151	3,464	2,796	923	2,068
81	2,823	3,223	3,547	2,861	944	2,115
82	2,882	3,294	3,620	2,922	965	2,160
83	2,950	3,368	3,705	2,989	988	2,212
84	3,014	3,442	3,786	3,054	1,009	2,257
85	3,102	3,540	3,895	3,144	1,037	2,322
86	3,166	3,617	3,977	3,209	1,059	2,372
87	3,233	3,693	4,060	3,277	1,082	2,422
88	3,298	3,768	4,143	3,344	1,104	2,472
89	3,366	3,846	4,229	3,413	1,127	2,522
90	3,435	3,923	4,314	3,480	1,150	2,575
91	3,504	4,002	4,401	3,551	1,173	2,626
92	3,571	4,081	4,486	3,621	1,196	2,675
93	3,640	4,158	4,571	3,689	1,219	2,727
94	3,707	4,235	4,655	3,756	1,241	2,776
95	3,771	4,307	4,735	3,819	1,263	2,825
96	3,827	4,373	4,809	3,879	1,281	2,870
97	3,879	4,432	4,874	3,933	1,298	2,908
98	3,920	4,479	4,926	3,974	1,312	2,939
99+	3,944	4,505	4,955	3,997	1,320	2,954

The above rates do not include the $20 one-time policy fee.

To calculate a 7% household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)

Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

PREMIUM INFORMATION

Aetna Health and Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state.

Premiums payable other than annually will be determined according to the following factors:

Semi-annual: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0833.

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under an Aetna Health and Life Insurance Company Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently have a Medicare supplement policy with an Aetna company. The Medicare eligible adult must be either (a) your spouse or someone with whom you are in a civil union partnership; and (b) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rates will be 7 percent lower than the individual rates and will apply as long as both policies remain in force.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Aetna Health and Life Insurance Company, P.O. Box 14770, Lexington, KY 40512-4770. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do **NOT** cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

The policy may not cover all of your medical costs. Neither Aetna Health and Life Insurance Company nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely any questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

THE FOLLOWING CHARTS DESCRIBE PLANS A, B, F, G, HIGH DEDUCTIBLE G, and N OFFERED BY AETNA HEALTH AND LIFE INSURANCE COMPANY.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$0	$1,632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,800 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,800 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – **NOT COVERED BY MEDICARE** Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum